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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 400 Session of 2009

INTRODUCED BY FERLO, BOSCOLA, O'PAKE, FONTANA, FARNESE, LEACH, HUGHES, MUSTO AND WASHINGTON, JULY 17, 2009

REFERRED TO BANKING AND INSURANCE, JULY 17, 2009

AN ACT

Providing for a Statewide comprehensive health care system; establishing the Pennsylvania Health Care Plan and providing for eligibility, services, coverages, subrogation, participating providers, cost containment, reduction of errors, tort remedies, administrative remedies and procedures, attorney fees, quality assurance, nonparticipating providers, transitional support and training; and establishing the Pennsylvania Health Care Agency, the Employer Health Services Levy, the Individual Wellness Tax and the Pennsylvania Health Care Board and providing for their powers and duties.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

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The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Family and Business Healthcare Security Act.

Section 102. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Agency." The Pennsylvania Health Care Agency established under this act.

"Board." The Pennsylvania Health Care Board established under this act.

"Certificate of need." A notice of approval issued by the Department of Health under the provisions of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, including those notices of approval issued as an amendment to an existing certificate of need.

"Department." The Department of Health of the Commonwealth.

"Executive director." The Executive Director of the Pennsylvania Health Care Board.

"Fund." The Pennsylvania Health Care Trust Fund established under this act.

"Individual Fair Share Health and Wellness Tax." The Individual Fair Share Health and Wellness Tax established under this act.

"Plan." The Pennsylvania Health Care Plan established under this act.

"Tax." The Employer Fair Share Health and Wellness Tax established under this act.

CHAPTER 3

ADMINISTRATION AND OVERSIGHT OF THE PENNSYLVANIA HEALTH CARE PLAN

SUBCHAPTER A

PENNSYLVANIA HEALTH CARE BOARD

Section 301. Organization.

(a) Composition.--The Pennsylvania Health Care Board shall be composed of 11 voting members. It shall be chaired by the executive director who may vote only in the event of a tie vote.

(b) Appointments.--

(1) The executive director shall be appointed by the Governor. The members of the board shall be appointed by the Governor, the President pro tempore of the Senate, and the Speaker of the House of Representatives who collectively shall make appointments of members from individuals representative of each of the following constituencies:

(i) Hospitals.

(ii) Organized labor, private sector.

(iii) Consumers.

(iv) Business.

(v) Agriculture.

(vi) Physicians.

(vii) Public sector employees.

(viii) Nurses.

(ix) Pharmacists.

(x) Long-term care facilities.

(xi) Social workers.

(2) The Governor shall initially appoint the executive director, who shall serve as chair of the board, appointments of the members shall thereafter be made in a rotating fashion beginning with the President pro tempore of the Senate, then the Speaker of the House of Representatives and then the Governor, with each in turn making an appointment from a constituency category not previously filled.

(c) Terms of members.--Each member appointed or reappointed under this section shall hold office for three years, starting on the first day of the first month following the member's appointment. A serving member of the board shall continue to serve following the expiration of the member's term until a successor takes office or a period of 90 days has elapsed, whichever occurs first.

(d) Midterm vacancies.--Midterm vacancies shall be filled by the same appointer and the individual appointed to fill a vacancy occurring prior to the expiration of the term for which a member is appointed shall hold office for the remainder of the predecessor's term.

(e) Compensation, benefits and expenses.--The executive director and members of the board shall receive an annual salary, benefits and expense reimbursement established by the board, to be paid from the fund. The initial board shall establish its own compensation. No increase or decrease in salary or benefits adopted by the board for the executive director or members shall become effective within the same

three-year term.

(f) Meetings.--

(1) The executive director shall set the time, place and date for the initial and subsequent meetings of the board and shall preside over its meetings. The initial meeting shall be set not sooner than 50 nor later than 100 days after the appointment of the executive director. Subsequent meetings shall occur at least monthly thereafter.

(2) All meetings of the board are open to the public unless questions of patient confidentiality arise. The board may go into closed executive session with regard to issues related to confidential patient information.

(g) Quorum.--Two-thirds of the appointed members of the board shall constitute a quorum for the conducting of business at meetings of the board. Decisions at ordinary meetings of the board shall be reached by majority vote of those actually present or, in the event of emergency meeting, those also present by electronic or telephonic means. Where there is a tie vote, the executive director shall be granted an additional vote to break the tie.

(h) Ethics.--The executive director, the members and their immediate families are prohibited from having any pecuniary interest in any business with a contract or in negotiation for a contract with the agency. The board shall also adopt rules of ethics and definitions of irreconcilable conflicts of interest that will determine under what circumstances members must recuse themselves from voting.

(i) Prohibitions.--

(1) No member of the board, except for the executive director, may receive any additional salary or benefits by

virtue of serving on the board.

(2) No member of the board may hold any other salaried Commonwealth public position, either elected or appointed, during the member's tenure on the board, including, but not limited to, the position of State legislator or member of the Congress of the United States.

(3) The executive director may not be a State legislator or member of the Congress of the United States.

Section 302. Duties of board.

(a) General duties.--The board is responsible for directing the agency in the performance of all duties, the exercise of all powers, and the assumption and discharge of all functions vested in the agency. The board shall adopt and publish its rules and procedures in the Pennsylvania Bulletin no later than 180 days after the first meeting of the board.

(b) Specific duties.--The duties and functions of the board include, but are not limited to, the following:

(1) Implementing statutory eligibility standards for benefits.

(2) Annually adopting a benefits package for participants of the plan.

(3) Acting directly or through one or more contractors as the single payer administrator for all claims for health care services made under the plan.

(4) At least annually, reviewing the appropriateness and sufficiency of reimbursements and considering whether a charge is fair and reasonable for its geographic region or location.

(5) Providing for timely payments to participating providers through a structure that is well organized and that

eliminates unnecessary administrative costs.

(6) Implementing standardized claims and reporting methods for use by the plan.

(7) Developing a system of centralized electronic claims and payments accounting.

(8) Establishing an enrollment system that will ensure that those who travel frequently and cannot read or speak English are aware of their right to health care and are formally enrolled in the plan.

(9) Reporting annually to the General Assembly and to the Governor, on or before the first day of October, on the performance of the plan, the fiscal condition of the plan, recommendations for statutory changes, the receipt of payments from the Federal Government, whether current year goals and priorities were met, future goals and priorities, and major new technology or prescription drugs that may affect the cost of the health care services provided by the plan.

(10) Administering the revenues of the fund.

(11) Obtaining appropriate liability and other forms of insurance to provide coverage for the plan, the board, the agency and their employees and agents.

(12) Establishing, appointing and funding appropriate staff, office space, equipment, training and administrative support for the agency throughout this Commonwealth, all to be paid from the fund.

(13) Administering aspects of the agency by taking actions that include, but are not limited to, the following:

(i) Establishing standards and criteria for the allocation of operating funds.

(ii) Meeting regularly to review the performance of the agency and to adopt and revise its policies.

(iii) Establishing goals for the health care system established pursuant to the plan in measurable terms.

(iv) Establishing Statewide health care databases to support health care services planning.

(v) Implementing policies and developing mechanisms and incentives to assure culturally and linguistically sensitive care.

(vi) Establishing rules and procedures for implementation and staffing of a no-fault compensation system for iatrogenic injuries or complications of care whereby a patient's condition is made worse or an opportunity for cure or improvement is lost due to the health care or medications provided or appropriate care not provided by participating providers under the plan.

(vii) Establishing standards and criteria for the determination of appropriate transitional support and training for residents of this Commonwealth who are displaced from work during the first two years of the implementation of the plan.

(viii) Evaluating the state of the art in proven technical innovations, medications and procedures and adopting policies to expedite the rapid introduction thereof in this Commonwealth.

(ix) Establishing methods for the recovery of costs for health care services provided pursuant to the plan to a beneficiary who is also covered under the terms of a policy of insurance, a health benefit plan or other collateral source available to the participant under

which the participant has a right of action for compensation. Receipt of health care services pursuant to the plan shall be deemed an assignment by the participant of any right to payment for services from any such policy, plan or other source. The other source of health care benefits shall pay to the trust all amounts it is obligated to pay to, or on behalf of, the participant for covered health care services. The board may commence any action necessary to recover the amounts due.

(14) Recruiting the Health Advisory Panel of seven members made up of a cross section of the medical and provider community. The members of the advisory panel shall be paid a per diem rate, established by the board, for attendance at meetings and further be reimbursed for actual and necessary expenses incurred in the performance of their duties, which shall include:

(i) Advising the board on the establishment of policy on medical issues, population-based public health issues, research priorities, scope of services, expansion of access to health care services and evaluation of the performance of the plan.

(ii) Investigating proposals for innovative approaches to the promotion of health, the prevention of disease and injury, patient education, research and health care delivery.

(iii) Advising the board on the establishment of standards and criteria to evaluate requests from health care facilities for capital improvements.

(iv) Evaluating and advising the board on requests from providers, or their representatives, for adjustments

to reimbursements.

(15) Establishing a secure and centralized electronic health record system wherein a beneficiary's entire health record can be readily and reliably accessed by authorized persons with the objective of eliminating the errors and expense associated with paper records and diagnostic films. The system shall ensure the privacy of all health records it contains.

SUBCHAPTER B

PENNSYLVANIA HEALTH CARE AGENCY

Section 321. Pennsylvania Health Care Agency.

(a) Establishment of agency.--There is hereby established the Pennsylvania Health Care Agency. The agency shall administer the plan and is the sole agency authorized to accept applicable grants-in-aid from the Federal Government and State government. It shall use such funds in order to secure full compliance with provisions of Federal and State law and to carry out the purposes established under this act. All grants-in-aid accepted by the agency shall be deposited into the Pennsylvania Health Care Trust Fund established under this act, together with other revenues raised within this Commonwealth to fund the plan.

(b) Appointment of executive director.--The executive director of the agency shall be appointed by the Governor for a term of three years and is the chief administrator of the plan.

(c) Personnel and employees.--The board shall employ and fix the compensation of agency personnel as needed by the agency to properly discharge the agency's duties. The employment of personnel by the board is subject to the civil service laws of this Commonwealth. The executive director shall oversee the operation of the agency and the agency's performance of any

duties assigned by the board.

SUBCHAPTER C

(Reserved)

SUBCHAPTER D

(Reserved)

SUBCHAPTER E

(Reserved)

SUBCHAPTER F

IMMUNITY

Section 371. Immunity.

In the absence of fraud or bad faith, the advisory panel, the board and agency and their respective members and employees shall incur no liability in relation to the performance of their duties and responsibilities under this act. The Commonwealth shall incur no liability in relation to the implementation and operation of the plan.

CHAPTER 5

PENNSYLVANIA HEALTH CARE PLAN

Section 501. General provisions.

(a) Establishment of plan.--There is hereby established the Pennsylvania Health Care Plan that shall be administered by the independent Pennsylvania Health Care Agency under the direction of the Pennsylvania Health Care Board.

(b) Coverage.--The plan shall provide health care coverage for all citizens of this Commonwealth and for certain eligible visitors. The agency shall work simultaneously to control health care costs, achieve measurable improvement in health care outcomes, promote a culture of health awareness and develop an integrated health care database to support health care planning and quality assurance.

(c) Reforms.--The board shall implement the reforms adopted by the General Assembly hereby within one year of the effective date of the plan.

Section 502. Universal health care access eligibility.

(a) Eligibility.--All Pennsylvania citizens, including an alien or immigrant lawfully given admission to the United States under the Immigration and Nationality Act (66 Stat. 163, 8 U.S.C. § 1101 et seq.), full-time out-of-State students attending school in this Commonwealth, homeless persons and migrant agricultural workers and their accompanying families are eligible beneficiaries under the plan. The board shall establish standards and a simple procedure to demonstrate proof of eligibility.

(b) Enrollment.--Enrollment in the plan shall be automatic and beneficiaries shall be provided with access cards with appropriate proof of identity technology and privacy protection.

(c) Waivers.--If waivers are not obtained from the medical assistance and/or Medicare programs operated under Title XVIII or XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), the medical assistance and Medicare nonwaived programs shall act as the primary insurers for those eligible for such coverage, and the plan shall serve as the secondary or supplemental plan of health coverage. Until such time as waivers are obtained, the plan will not pay for services for persons otherwise eligible for the same benefits under Medicare or Medicaid. The plan shall also be secondary to benefits provided to military veterans except where reasonable and timely access, as defined by the board, is denied or unavailable through the United States Veterans' Administration, in which instance the plan will be primary and will seek reasonable reimbursement from

the United States Veterans' Administration for the services provided to veterans.

(d) Priority of plans.--A plan of employee health coverage provided by an out-of-State employer to a Pennsylvania resident working outside of this Commonwealth shall serve as the employee's primary plan of health coverage, and the plan shall serve as the employee's secondary plan of health coverage.

(e) Reimbursement.--The plan shall reimburse providers practicing outside of this Commonwealth at plan rates, or the reasonable prevailing rate of the locale where the service is provided, for health care services rendered to a beneficiary while the beneficiary is out of this Commonwealth. Services provided to a beneficiary out of this Commonwealth by other than a participating provider shall be reimbursed to the beneficiary or to the provider at a fair and reasonable rate for that location.

(f) Presumption of eligibility.--Any individual who arrives at a health care facility unconscious or otherwise unable due to their mental or physical condition to document eligibility for coverage shall be presumed to be eligible, and emergency care shall be provided without delay occasioned over issues of ability to pay.

(g) Rules.--The board shall adopt rules assuring that any participating provider who renders humanitarian emergency or urgent care within this Commonwealth to a not actually eligible recipient shall nevertheless be reimbursed for such care from the plan subject to such rules as will reasonably limit the frequency of such events to protect the fiscal integrity of the plan. It shall be the agency's responsibility to secure reimbursement for the costs paid for such care from any

appropriate third party funding source, or from the individual to whom the services were rendered.

Section 503. Covered services.

(a) Benefits package.--The board shall establish a single health benefits package within the plan that shall include, but not be limited to, all of the following:

(1) All medically necessary inpatient and outpatient care and treatment, both primary and secondary.

(2) Emergency services.

(3) Emergency and other medically necessary transport to covered health services.

(4) Rehabilitation services, including speech, occupational, physical and massage therapy.

(5) Inpatient and outpatient mental health services and substance abuse treatment.

(6) Hospice care.

(7) Prescription drugs and prescribed medical nutrition.

(8) Vision care, aids and equipment.

(9) Hearing care, hearing aids and equipment.

(10) Diagnostic medical tests, including laboratory tests and imaging procedures.

(11) Medical supplies and prescribed medical equipment.

(12) Immunizations, preventive care, health maintenance care and screening.

(13) Dental care.

(14) Home health care services.

(15) Chiropractic and massage therapy.

(16) Complementary and alternative modalities that have been shown by the National Institute of Health's Division of Complementary and Alternative Medicine to be safe and

effective for possible inclusion as covered benefits.

(17) Long-term care for those unable to care for themselves independently and including assisted and skilled care.

(b) Exclusions for preexisting conditions.--The plan shall not exclude or limit coverage due to preexisting conditions.

(c) Copayments, deductibles, etc.--Beneficiaries of the plan are not subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package and shall not be directly billed nor balance billed by participating providers for covered benefits provided to the beneficiary. Where a beneficiary has directly paid for nonemergency services of a nonparticipating provider, the beneficiary may submit a claim for reimbursement from the plan for the amount the plan would have paid a participating provider for the same service. Where emergency services are rendered by a nonparticipating provider, the beneficiary shall receive reimbursement of the full amount paid to such nonparticipating provider not to exceed 125% of the amount the plan would have paid a participating provider for the same service.

(d) Exclusions of coverage.--

(1) The board shall remove or exclude procedures and treatments, equipment and prescription drugs from the plan benefit package that the board finds unsafe or that add no therapeutic value.

(2) The board shall exclude coverage for any surgical, orthodontic or other procedure or drug that the board determines was or will be provided primarily for cosmetic purposes unless required to correct a congenital defect, to restore or correct disfigurements resulting from injury or

disease or that is certified to be medically necessary by a qualified, licensed provider.

(e) Choice by beneficiary.--Beneficiaries shall normally be granted free choice of the participating providers, including specialists, without preapprovals or referrals. However, the board shall adopt procedures to restrict such free choice for those individuals who engage in patterns of wasteful or abusive self-referrals to specialists. Specialists who provide primary care to a self-referred beneficiary will be reimbursed at the board-approved primary care rate established for the service in that community.

(f) Service.--No participating provider shall be compelled to offer any particular service so long as the refusal is consistent with the provider's practice and is in no way discriminatory.

(g) Discrimination.--The plan and participating providers shall not discriminate on the basis of race, ethnicity, national origin, gender, age, religion, sexual orientation, health status, mental or physical disability, employment status, veteran status or occupation.

Section 504. Excess and collective bargaining agreement health insurance coverage.

Subject to the regulations of the Insurance Commissioner and all applicable laws, private health insurers shall be authorized to offer coverage supplemental to the package approved and provided automatically under this act.

Section 505. Duplicate coverage.

The agency is subrogated to and shall be deemed an assignee of all rights of a beneficiary who has received duplicate health care benefits, or who has a right to such benefits, under any

other policy or contract of health care or under any government program.

Section 506. Subrogation.

The agency shall have no right of subrogation against a beneficiary's third-party claims for harm or losses not covered under this act. Nor shall any beneficiary under this act have a claim against a third-party tortfeasor for the services provided or available to the beneficiary under this act. In all personal injury actions accruing and prosecuted by a beneficiary on or after January 1, 2008, the presiding judge shall advise any jury that all health care expenses have been or will be paid under the plan, and, therefore, no claim for past or future health care benefits is pending before the court.

Section 507. Eligible participating providers and availability of services.

(a) General rule.--All licensed health care providers and facilities are eligible to become a participating provider in the plan in which instance they shall enjoy the rights and have the duties as set forth in the plan as stated in this section or as adopted by the board from time to time. Nonparticipating providers shall not enjoy the rights nor bear the duties of participating providers.

(b) Required notice.--In advance of initially providing services to a beneficiary, nonparticipating providers shall advise the beneficiary at the time the appointment is made that the person or entity is a nonparticipating provider and that the recipient of the service will be initially personally responsible for the entire cost of the service and ultimately responsible for the cost in excess of the reimbursement approved by the board for participating providers. Failure to make such

financial disclosure will be deemed a fraud on the beneficiary and entitle the beneficiary to a refund from the provider equal to 200% of the amount paid to the nonparticipating provider in excess of the board-approved reimbursement for the services rendered, plus all reasonable fees for collection. The burden of proof that such disclosure was made shall be on the nonparticipating provider.

(c) Plan by board.--The board shall assess the number of primary and specialty providers needed to supply adequate health care services in this Commonwealth generally and in all geographic areas and shall develop a plan to meet that need. The board shall develop financial incentives for participating providers in order to maintain and increase access to health care services in underserved areas of this Commonwealth.

(d) Reimbursements.--Reimbursements shall be determined by the board in such a fashion as to assure that a participating provider receives compensation for services that fairly and fully reflect the skill, training, operating overhead included in the costs of providing the service, capital costs of facilities and equipment, cost of consumables and the expense of safely discarding medical waste, plus a reasonable profit sufficient to encourage talented individuals to enter the field and for investors to make capital available for the construction of state-of-the-art health care facilities in this Commonwealth.

(e) Adjustments to reimbursements.--Participating providers shall have the right alone or collectively to petition the board for adjustments to reimbursements believed to be too low. Such petitions shall be initially evaluated by the administrator of provider services, with input from the Health Advisory Panel, who shall submit a report to the executive director within 30

days. The executive director will then submit a recommendation to the board for action at the next scheduled board meeting. Participating providers who remain dissatisfied after the board has ruled may appeal the board's determination to Commonwealth Court, which shall review the action of the board on an abuse of discretion standard.

(f) Evaluation of access to care.--The board annually shall evaluate access to trauma care, diagnostic imaging technology, emergency transport and other vital urgent care requirements and shall establish measures to assure beneficiaries have equitable and ready access to such resources regardless of where in this Commonwealth they may be.

(g) Performance reports.--The board, with the assistance of the Health Advisory Panel, shall define performance criteria and goals for the plan and shall make a written report to the General Assembly at least annually on the plan's performance. All such reports, including the survey results obtained, shall be made publicly available with the goal of total transparency and open self-analysis as a defining quality of the agency. The board shall establish a system to monitor the quality of health care and patient and provider satisfaction and to adopt a system to devise improvements and efficiencies to the provision of health care services.

(h) Data reporting.--All participating providers shall, in a prompt and timely manner, provide existing and ongoing data to the agency upon its request.

(i) Coordination of services.--The board shall coordinate the provision of health care services with any other Commonwealth and local agencies that provide health care services directly to their charges or residents.

Section 508. Rational cost containment.

(a) Approval of expenditures.--As part of its cost containment mission and based on the certificate of need, the board shall screen and approve or disapprove private or public expenditures for new health care facilities and other capital investments that may lead to redundant and inefficient health care provider capacity. Procedures shall be adopted for this purpose with an emphasis upon efficiency, quality of delivery and a fair and open consideration of all applications.

(b) Capital investments.--Based on the certificate of need all capital investments valued at $1,000,000 or greater, including the costs of studies, surveys, design plans and working drawing specifications, and other activities essential to planning and execution of capital investment and all capital investments that change the bed capacity of a health care facility by more than 10% over a 24-month period or that add a new service or license category shall require the approval of the board. When a facility, an individual acting on behalf of a facility or any other purchaser obtains by lease or comparable arrangement any facility or part of a facility, or any equipment for a facility, the market value of which would have been a capital expenditure, the lease or arrangement shall be considered a capital expenditure for purposes of this section.

(c) Study.--Those intending to make capital investments or acquisitions shall prepare a business case for making each investment and acquisition. It shall include the full-life-cycle costs of the investment or acquisition, an environment impact report that meets existing State standards and a demonstration of how the investment or acquisition meets the health care needs of the population it is intended to serve. Acquisitions may

include, but not be limited to, acquisitions of land, operational property or administrative office space.

(d) Deemed approval.--Capital investment programs submitted for approval shall be deemed approved by the board within 60 days from the date the submissions are received by the executive director. A 60-day extension may apply if the board requires additional information.

(e) Recommendations.--Recommendations of the Pennsylvania Heath Cost Containment Council and such other public and private authoritative bodies as shall be identified from time to time by the board shall be received by the executive director and submitted to the board with the executive director's recommendation regarding implementation of the recommended reforms. The board shall receive input from all interested parties and then shall vote upon all such recommendations within 60 days. Where procedural or protocol reforms are adopted, participating providers will be required to implement such designated best practices within the next 60 days.

(f) Appeal.--A decision of the board may be appealed through a uniform dispute resolution process that has been established by unanimous approval of the board.

(g) Required investments.--The board is authorized to adopt programs to assist participating providers in making capital investments responsive to best practice recommendations.

(h) Decertification.--Participating providers refusing to adopt recommended reforms shall, after a reasonable opportunity to be heard, be subject to such sanctions as the board shall deem appropriate and necessary up to and including the suspension or permanent decertification of the participating provider.

CHAPTER 9

PENNSYLVANIA HEALTH CARE TRUST FUND

Section 901. Pennsylvania Health Care Trust Fund.

(a) Establishment.--The Pennsylvania Health Care Trust Fund is hereby established within the State Treasury. All moneys collected and received by the plan shall be transmitted to the State Treasurer for deposit into the fund, to be used exclusively to finance the plan.

(b) State Treasurer.--The State Treasurer may invest the principal and interest earned by the fund in any manner authorized under law for the investment of Commonwealth moneys. Any revenue or interest earned from the investments shall be credited to the fund.

Section 902. Limitation on administrative expense.

The system budget referred to in this chapter shall comprise the cost of the agency, services and benefits provided, administration, data gathering, planning and other activities and revenues deposited with the system account of the fund. The board shall limit ongoing administrative costs, excluding start-up costs, to 5% of the agency budget and shall annually evaluate methods to reduce administrative costs and publicly report the results of that evaluation.

Section 903. Funding sources.

Funding of the plan shall be obtained from the following dedicated sources:

(1) Funds obtained from existing or future Federal health care programs.

(2) Funds from dedicated sources specified by the General Assembly.

(3) Receipts from the tax of 10% of gross payroll,

including self-employment profits. One percent of the tax shall become effective the date that shall be the first day of a calendar month no less than 32 days after the effective date of this act, and the tax shall become fully effective 60 days before the plan takes effect. Employers who are part of a collective bargaining agreement whereby the health care benefits are no less generous than those provided under the plan shall be excused from paying 90% of the tax.

(4) Receipts from the Individual Fair Share Health and Wellness Tax of 3% on income as defined in sections 301 and 303 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. One-half of one percent of the Individual Fair Share Health and Wellness Tax shall become effective the date that shall be the first day of a calendar month no less than 32 days after the effective date of this act, and the Individual Fair Share Health and Wellness tax shall become fully effective 60 days before the plan takes effect.

(5) In the event the General Assembly has not responded to a request by the board for an increase in funding in anticipation of projected expenses, the board is hereby authorized to order a temporary increase, for no more than 90 days, in the tax and/or the Individual Fair Share Health and Wellness Tax of not more than 250 basis points each to respond to a threatened insolvency of the plan.

CHAPTER 11

TRANSITIONAL SUPPORT AND TRAINING FOR DISPLACED WORKERS

Section 1101. Transitional support and training for displaced workers.

(a) Determination of eligibility.--The plan shall determine

which citizens of this Commonwealth employed by a health care insurer, health insuring corporation or other health care-related business have lost their employment as a result of the implementation and operation of the plan, including the amount of monthly wages that the individual has lost due to the plan's implementation. The plan shall attempt to position these displaced workers in comparable positions of employment or assist in the retraining and placement of such displaced employees elsewhere.

(b) Compensation.--The plan shall forward the information on the amount of monthly wages lost by Commonwealth residents due to the implementation of the plan to the board. Compensation shall be up to $5,000 each month but may not exceed the monthly wages of the individual when he was displaced. Compensation will cease upon reemployment or after two years, whichever comes first. A displaced worker shall be eligible to receive compensation, training assistance, or both, from the fund. Training assistance may not exceed $20,000.

(c) Coordination of services.--The plan shall fully coordinate activity with public and private services also available or actually participating in the assistance to the affected individuals.

(d) Appeals.--Persons dissatisfied with the level of assistance they are receiving may appeal to the office of the executive director whose determination shall be final and not subject to appeal.

CHAPTER 13

VOLUNTEER EMERGENCY RESPONDER NETWORK

Section 1301. Preservation of volunteer emergency responder network.

Because this Commonwealth is dependent upon the volunteered services of firefighters, emergency medical technicians and search and rescue workers, the board is further charged with administering a Commonwealth income tax credit program for such volunteers.

Section 1302. Eligibility certification.

Annually, in January, administrators of volunteer firefighting and rescue departments, emergency medical technicians and paramedics stations and similar volunteer emergency entities shall certify the identity of Commonwealth residents providing active services during the prior calendar year.

Section 1303. Eligibility criteria.

Active status shall require a minimum of 200 hours of service during the preceding year and response to no less than 50% of the emergency calls during at least three of the four calendar quarters.

Section 1304. Amount of tax credit.

Each volunteer certified as active shall be granted a credit equal to $1,000 toward their State income tax obligation under Article III of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. Any eligible volunteer who does not incur $1,000 in annual State income tax liability shall nevertheless be eligible for a refund equal to the amount the credit exceeds that volunteer's tax obligation.

Section 1305. Reimbursement.

The State Treasury shall be reimbursed the value of such volunteer credits from the fund.

CHAPTER 45

MISCELLANEOUS PROVISIONS

Section 4501. Effective date.

This act shall take effect immediately.